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ABSTRACT

Recent national data suggests that there is a similarity between the prevalence of clinically defined mental health problems, as well as comorbidity including substance abuse, among rural and urban adult populations. However, due to the lack of a mental health and substance abuse infrastructure in rural areas, many times these disorders go untreated. This issue paper offers the following 10 recommendations for addressing the problems of mental health care in rural America: (1) encourage integrated interdisciplinary approaches combining mental health and addiction treatment; (2) create incentives offsetting states' cost of developing and maintaining current data on the distribution of mental health professionals by gaining access to federal dollars or mental health professionals; (3) increase the availability of interdisciplinary training for rural mental health providers; (4) develop and support training programs integrating mental health providers and primary care practitioners with the mental health system; (5) have contractors monitor the impact of their policies on the effectiveness of mental health services provided to rural beneficiaries; (6) conduct rural mental health programs in a culturally competent manner; (7) provide community based programs that lend support to self help groups, consumer operated services, and consumer roles in policy and governance of mental health services; (8) encourage mental health professions to examine their current training programs and internships; (9) urge federal agencies to support and fund this agenda; (10) encourage federal agencies to add their research on the development and evaluation of mental health outreach services designed to overcome rural barriers to help-seeking. (Contains 22 references.) (ADT)

National Rural Health Association

Mental Health in Rural America

An Issue Paper Prepared by the National Rural Health Association -- May 1999

THE SCOPE OF MENTAL HEALTH ISSUES IN RURAL AMERICA

Natural and Economic Trauma

- Like the fuse on a time bomb burning shorter and shorter, the stress a farmer feels intensifies with each new setback. At first it's the pain and embarrassment of not being able to pay the bills. The farm couple seeks help from the lending institutions that once encouraged them to go more heavily into debt, only to be turned away. They're told that they're a bad risk and poor managers. In the next phase, with no money for food or gasoline, they become prisoners in their own home. Every day they walk to the mailbox, only to receive another stack of legal documents telling them that they will lose the farm. Then the foreclosure notice arrives and, inevitably, after years of dreaded anticipation, the farm auction is scheduled. As the final blow, they are forced to look on as strangers, and sometimes friends and neighbors, bid pennies on the dollar and walk away with their life's work, which includes their parents' and grandparents' life work. All the while, the family has been falling apart. Family members are in poor health, but they can't afford a doctor. The adults-and often their teen-age children-have been drinking more to dull the pain. They argue constantly. Parents hit their kids and each other. In the end, they don't recognize themselves or anything in the world around them. Death makes sense-it would be easier (Dyer, 1997).
- A 35-year-old man drove 200 miles to an Albuquerque, N.M., emergency room with a .22 caliber pistol in his hand because he felt suicidal. He stated that he had spent the night in a field near his home, repeatedly holding the gun to his head and then "losing nerve" and shooting into the sky. The man said that two weeks earlier he himself had found a suicide victim, and since that time, he could not rid himself of the idea of killing himself. He reported nightmares, intrusive thoughts, irritability, avoidance and anxiety. He had not sought care because he didn't want to be identified going to the rural "mental clinic" and had little money to go elsewhere. "Everyone watches who goes in there," he said. "My mom works down the street. If you go in, they think you are crazy. I didn't want them to know I was weak. I didn't want to lose my job. I didn't want the whole town to know I was nuts" (Roberts, et al., 1999).
- "Numbness is a defense mechanism, but a person does not have good judgment in that state, especially when the stakes are so high. It's hard to suggest to a stubborn, independent farmer to seek

help, and what worked for me was to call help 'in' and ask them to come to us. Many of our friends who are floundering the most have not succumbed to the notion of outside help, and so on top of the economic stress, they are struggling-and my heart aches for them" (Zimmerman, 1999).

Stories like these, from rural residents in farming, mining, forestry and fishing-dependent rural economies, tell of the chronic stress experienced by rural families in these occupations. Like post-traumatic stress disorder, such stress, experienced over years of uncertainty and compromised traditional rural values, takes its toll. While the farm crisis of the 1980s was originally perceived as an economic crisis, studies have shown that it was also a "sociological, psychological and emotional crisis." As one farmer put it, when the traditional rural values of hard work, independence, religious beliefs and patriotism fail to sustain a family, "I feel God has abandoned me" (Heffernan, 1999). Unfortunately, the farm (and other rural-based industry) crisis and all of its mental health consequences continue to this day.

General Prevalence of Mental Health Disorders in Rural Areas

Although the evidence is not entirely conclusive, the most recent national data available suggest that the prevalence of clinically defined mental health problems among rural and urban adult populations is similar (Kessler, et al., 1994). Analysis of data from the National Comorbidity Survey indicates that, if anything, the 12-month prevalence of any affective or anxiety disorders is lower in rural than in urban areas. The lifetime prevalence of any affective disorder is likewise lower in rural than in urban areas, whereas the lifetime prevalence of any anxiety disorder appears to be roughly equivalent regardless of residence location. These findings are consistent with those from the National Household Survey on Drug Abuse, which likewise note no major differences in prevalence by urbanicity of residence for a variety of common psychiatric diagnoses.

Similarly, the overall prevalence in rural areas of alcohol and other substance use among adults has repeatedly been shown to be of at least the same magnitude as urban areas although there are certain rural areas where the use of a specific drug is particularly problematic (e.g., methamphetamines). The National Comorbidity Survey found comparable lifetime and 12-month prevalence rates for any substance abuse disorder among its respondents regardless of residence.

It is noteworthy that mental disorders are often accompanied by co-occurring disorders that include addictions. Although rural data that speak to this are not available, it is known that, for the entire country, as many as 70 percent of individuals treated for substance abuse have a lifetime history of depression (Mirin, et al., 1988). According to the National Institute of Mental Health (NIMH) Epidemiologic Catchment Area study, individuals with either a mental health or substance use disorder are more likely to have a co-occurring disorder (Regier, et al., 1990). The study found that 23 percent to 56 percent of individuals with a diagnosable Axis I mental disorder also have a substance abuse or dependence disorder (Regier, et al., 1990). The few rural studies on co-occurring mental health and substance abuse disorders indicate no urban-rural differences in the prevalence of such comorbidities. While these studies indicate no differences, the serious lack of a mental health and substance abuse infrastructure means that, in rural areas, they often go untreated.

Recommendation 1.

To provide simultaneous treatment to rural residents who have been diagnosed as having co-occurring disorders, integrated interdisciplinary approaches combining mental health and addiction treatment should be encouraged and funded in rural America.

THE RURAL MENTAL HEALTH INFRASTRUCTURE

There is substantial evidence that the number of mental health providers in rural America is inadequate. As of 1990, only 79.5 percent of nonmetropolitan counties in the United States had any mental health services (Hartley, et al., 1999). The average number of specialty mental health organizations in nonmetropolitan counties is also substantially lower than the average number in metropolitan counties. In general, we associate lower availability of services with lower access to services. For example, a study conducted in Maine found that the supply of mental health professionals explained much of the observed difference in access to and use of mental health services (Lambert, et al., 1995). Current data show consistently lower availability of hospital-based inpatient and outpatient services, both psychiatric and substance abuse, in rural areas (Hartley, et al., 1999).

The National Health Service Corps (NHSC) has identified clinical psychologists, psychiatrists, psychiatric nurses, clinical social workers, and marriage and family counselors as mental health providers eligible for loan repayment in exchange for service in mental health professional shortage areas (MHPSAs). As of Dec. 31, 1997, 76 percent of the 518 designated MHPSAs in the United States were located in nonmetropolitan areas with a total population of more than 30 million. These shortage designations are based solely on the distribution of psychiatrists, because national data on the availability and distribution of the other four mental health professions listed above are not available and it is costly for states to maintain current data sufficient to use all five professions in the shortage designation process. While data on the distribution of primary care practitioners is kept current due to the large number of federal and state programs that depend on such data, the mental health professions have not received similar attention.

Recommendation 2.

Incentives must be created so that the cost to states of developing and maintaining current data on the distribution of mental health professionals is offset by gains in access to federal dollars or NHSC mental health professionals.

An estimated two-thirds of U.S. patients with clinical symptoms of mental illness receive no care at all for such symptoms. Of those who do receive formal treatment, approximately 40 percent receive care from a mental health specialist and 45 percent from a general medical practitioner (Regier, et al., 1993). Due to the documented lack of specialty mental health services, the proportion of mental health care provided by primary care practitioners in rural America is probably greater than this national average. In fact, rural residents under continuing treatment for mental health conditions have been found significantly more likely to receive this care exclusively from a general medical practitioner (Rost, et al., 1998).

Contributing to the role of primary care practitioners in providing mental health services is the stigma attached to having a mental disorder in rural areas. This reality leads to under-diagnosis and under-treatment of mental disorders among rural residents. When treatment is sought, it is often in the guise of a physical complaint, hence the role of the primary care physician in the screening and treating or referring for treatment of mental disorders looms larger in rural areas. Because primary care physicians are the dominant providers of mental health care in rural areas and because they often lack specific mental health training, interdisciplinary collaboration (including referral to a mental health specialist) and training involving the other professions is needed.

The disciplines of medicine, psychology, nursing, social work and counseling complement each other well, and their relationship is a natural alliance. Collaboration between professionals in these fields has been used to prevent and treat a wide variety mental and physical conditions. Such interdisciplinary collaboration is especially needed in rural America where interdisciplinary training programs for the mental health professions can, in part, compensate for the lack of mental health care personnel. Interdisciplinary team training for rural mental health care provides the means to serve these communities in ways that will maximize the services provided by a limited number of personnel over a wide geographic area.

The nature of interdisciplinary approaches is best summed up in the definition of "interdisciplinary" contained in the curriculum developed by the American Psychological Association (APA)-"An integrated approach in which the various disciplines work together in the diagnosis and treatment of patients." Interdisciplinary work requires collaboration and an appreciation of the practice style of all the disciplines. Primary care physicians are vital members of the interdisciplinary team. Because rural residents have no hesitation in seeking treatment from them for physical complaints, primary care physicians must be capable of screening and recognizing mental disorders, providing brief therapy when warranted, and making referrals to mental health professionals when appropriate.

Recommendation 3.

The Quentin Burdick Rural Interdisciplinary Training Grant Program operated by the Bureau of Health Professions, Health Resources and Services Administration (HRSA), should be reauthorized and expanded to increase the availability of interdisciplinary training for rural mental health providers with primary care practitioners. Other health professions training programs funded by HRSA (e.g., Area Health Education Centers, Geriatric Education Centers, etc.) should be encouraged as well to increase the availability of such interdisciplinary training.

A lack of services or professionals in the immediate area does not always mean a complete lack of access. Rural residents often are willing to drive to urban areas for services. In fact, they sometimes prefer to do this for the sake of anonymity. On the other hand, when a psychiatric or substance abuse crisis occurs, local services are essential to avoid the trauma of transport to the state psychiatric hospital in a law enforcement vehicle and to prevent escalation of the problem to a level that may require more intensive care (Wilson, et al., 1995). Unfortunately, the lack of professionals often means that rural hospitals cannot provide crisis services. Among nonmetropolitan hospitals nationwide, 18.6 percent offer emergency psychiatric services, compared with 37.4 percent of metropolitan hospitals.

The observation has been made (Fox, et al., 1995) that mental health services in rural areas are scarce and that, when provided, they are delivered through the general medical sector rather than through formal mental health specialist services. This implies a de facto system that combines specialty mental health services with general medical services and includes nursing home care, lay workers, self-help consumer-operated services, the faith community, agricultural extension agents, other health providers (e.g., pharmacists, chiropractors), and law enforcement.

Some of the authors of the paper on de facto providers have, in addition, explored help-seeking behavior for mental disorders in a rural impoverished population (Fox, et al., 1998). Facilitating help-seeking is necessary with rural populations to overcome the effects of poverty, lack of insurance and rural cultural bias (including stigma). The findings reinforced the importance of the de facto concept: that motivating individuals to seek mental health services is a complex process and that more attention must be devoted to culturally relevant methods for facilitating help-seeking.

Recommendation 4.

Interdisciplinary training programs must be developed and supported that integrate mental health providers and primary care practitioners with the de facto mental health system. A curriculum for a community-based rural model of training has been published by the APA (1995). Federal and state grants are needed to develop rural mental health service systems through such community-oriented training.

ORGANIZATIONAL ISSUES

State Medicaid agencies have emerged as major state-level players in the changing structure of the mental health services system. While state mental health offices devote their limited resources to planning, operating or regulating programs and services for seriously and persistently mentally ill adults and seriously emotionally disturbed children, the state Medicaid agency pays for most of these programs and services. As states have moved their Medicaid populations into managed care programs, they have often "carved out" the mental health benefits and transferred the management of those benefits to specialty firms known as managed behavioral health organizations (MBHOs).

Under a "carve out" system behavioral health is separated from primary and other health care services. This can create complex authorization procedures, long or redundant reviews, power struggles about cost shifting, and another layer of referral if the patient has to go through a primary care physician to get to the behavioral health provider. Instead of fostering integration, this can promote fractionation. On the other hand, when MBHOs develop provider panels, they sometimes overlook the role of primary care physicians who provide mental health services in rural areas. This phenomenon caused serious access problems in Montana in 1997 (Lambert, et al., 1998). In addition, the MBHOs often will place severe restrictions on outpatient psychotherapy under the guise of cost reduction that limits the effectiveness of this form of treatment (Wear, 1999).

Another effect of managed behavioral health care has been a reduction of in-patient lengths of stay. MBHOs have accomplished this as a cost-saving strategy in response to states' demanding reduced mental health costs for the Medicaid population. Earlier discharge may not be a problem in urban areas where community services such as partial hospitalization can support patients recovering from serious mental illness, but these services are rarely available in rural areas. Thus, rural residents hospitalized for mental illness may be at increased risk for relapse and readmission.

Recommendation 5.
State Medicaid agencies contracting with MBHOs must require their contractors to monitor the impact of their policies on the effectiveness of the mental health services provided to rural beneficiaries.

CONSUMER ISSUES

Cultural Competence

"In rural culture, deeply held religious beliefs are often intertwined with patriotic beliefs about the spiritual value as well as the economic and social benefits of such things as hard work, of living a faith-filled, family and community-centered life, of being an independent, upstanding, God-fearing, patriotic American. This complex interplay of beliefs and values made it nearly impossible in the '80s to respond to hurting rural folks simply as bearers of mental health problems that needed to be fixed" (Heffernan, 1999).

To achieve cultural competence, mental health providers in rural areas must have an understanding of and an appreciation for cultural differences and similarities within, among and between groups. This requires the acquisition of academic and interpersonal skills that will increase understanding and a willingness and an ability to draw on community-based values, traditions and customs to work with people from the community in developing interventions, communications and other prevention and treatment options that address mental health problems (APA, 1995). The goals of cultural competence include:

1. identifying social, economic, political and religious influences affecting rural communities;
2. understanding the importance of ethnic and cultural influences in rural communities and the

importance of the oral tradition;
3. understanding the impact of the interaction between social institutions and ethnicity on the delivery of mental health services;
4. recognizing the impact of the provider's own culture, sensitivity and awareness as it affects his or her ability to deliver mental health care; and
5. understanding alternative treatment sources in the ethnic minority culture.

Recommendation 6.
All rural mental health programs should be conducted in a culturally competent manner that recognizes the local rural culture and those of the various ethnic groups (e.g., African Americans, Native Americans) that comprise the local population. To achieve this goal, additional initiatives should be funded to provide training in cultural competence. In addition, rural disciplinary and interdisciplinary programs must attend to the goal of cultural competence.

Needs and roles of consumers who use services on an ongoing basis (with chronic or persistent mental problems) are of paramount importance in designing policy and providing mental health treatment. This is particularly true in rural areas where the danger of consumer isolation is high.

Recommendation 7.
Community-based programs at the state and federal level are needed to support self-help groups, consumer-operated services, and consumer roles in policy and governance of mental health services. The NRHA recommends increased funding for case management, social clubs or support groups, and other modalities as a means of decreasing relapse rates.

TRAINING ISSUES

To ensure the availability of sufficient numbers of mental health providers in rural areas, the various mental health professions should recruit students from rural areas and offer training and internship programs with a rural emphasis. A directory has been published (APA, 1998) listing more than 100 internships and 50 training programs in psychology that have self-identified a rural emphasis. In addition to professional training programs, there is a need for the mental health professions to identify and make available continuing education in the arena of rural mental health services delivery. As the effects of the changing health care market are felt by mental health providers, continuing education can equip individual providers to function in a rural setting by providing interdisciplinary skills and training in new modalities, such as telehealth, that have the potential to improve the delivery of rural mental health services.

Recommendation 8.
All mental health professions are encouraged to examine their current professional training programs and internships to identify and expand those with a rural emphasis. Medical schools and residencies training primary care practitioners also are encouraged to address the mental health needs of rural patients in their curricula.

RURAL MENTAL HEALTH SERVICES RESEARCH

There are many gaps in knowledge, particularly in the area of rural mental health services that require research. The support of rural mental health services research began with the advent of the Community Mental Health Centers during the 1960s and 1970s during the "deinstitutionalization" that occurred during that period. Mental health services research was undertaken to find better ways of delivering mental health services in a community setting. As we approach the year 2000, the structure of the mental health delivery system, especially in rural and frontier America, is undergoing profound change, and research must be undertaken to discover better ways to deliver mental health care that recognizes the systemic changes that are underway. In recognition of these changes, the Office of Rural Mental Health Research, NIMH, has supported a series of research planning conferences that has yielded the following agenda:

- mental health care delivery in primary care settings;
- the role of telecommunications (telehealth) in the delivery of mental health services to rural and frontier populations;
- prevention of mental health problems in rural and frontier America;
- delivery of culturally competent mental health care to all populations in rural and frontier America;
- the role of managed care in the delivery of rural mental health services; and
- conceptual and research methodologies to enhance the understanding and measurement of mental health service in rural and frontier communities.

Recommendation 9.
The NRHA endorses this agenda and urges the NIMH, HRSA and Substance Abuse and Mental Health Services Administration to support it and to provide the leadership and funding to accomplish it.

Funding for innovative models to deliver services to homeless persons with mental illness has gone almost exclusively to urban areas. While the need for outreach and community-based services to such urban residents is undisputed, to achieve rural parity in mental health services similar funding is needed for the development of mental health outreach services designed to overcome uniquely rural barriers to help-seeking.

Recommendation 10.
The NRHA encourages the NIMH to add to its research agenda the development and evaluation of mental health outreach services designed to overcome uniquely rural barriers to help-seeking.

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